BULLETIN OF
THE NEW YORK ACADEMY
OF MEDICINE

VOL. 51, NO. 1 JANUARY 1975

PREVENTION AND HEALTH MAINTENANCE REVISITED*

Opening Statement

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FOR many, the slogan of prevention is worn threadbare. It is hardly more exciting than its folklore equivalent that "a stitch in time saves nine," and we can count ourselves fortunate to have so large an attendance. It is clear that the task of prevention is not done. We might safely say that the task of prevention is never done.

The diseases that beset society evolve and change, and what serves today will not serve for tomorrow. Indeed, what we are doing today does not serve even for today, and so the Committee on Medicine in Society of the Academy of Medicine thought it timely to reexamine the question of prevention. As befits the name and the purposes of the committee, this examination is made from the angle of communities and societies. That is to say, we shall go beyond the problems and the practice of the individual physician in his one-to-one relation with patients to consider the mass application of preventive measures in

*The 1974 Annual Health Conference of the New York Academy of Medicine, April 25 and 26, 1974.

terms of the public health. Only by assuming the broad community perspective and aiming systematically at a target population can we hope that any measure will have an impact on the health of society. We cannot rely on sporadic exchanges of episodic care between physician and patient to affect the health of communities; although such exchanges do affect the health of individuals, that is all they aim and can hope to do. Every intervention by a physician, it can be argued, aims at preventing something. At the extreme he is trying to prevent death or permanent impairment; or he may be trying to prevent the prolongation of an illness. The term "prevention" in medicine connotes more than that undiscriminating meaning, and usually something different from it as well.

When we talk of prevention, we are talking about intervention over and above the treatment solicited by the sick patient from the health professional. We refer, rather, to the treatment that is solicited by the health professional from the potential patient. A person who is not sick or impaired, or who is impaired but has not recognized it, and who has not assumed the sick role in which the social expectation is that he will solicit professional help, now becomes the object of the health professional's solicitation. That substantially changes the form of the relations.

To distinguish these various types of preventive activity, the late Gurney Clark, my predecessor at Columbia, offered a well known tripartite classification that remains useful. He distinguished primary prevention (which is to prevent the onset of disease as by sanitation or vaccination) from secondary prevention (which is to prevent the progress of disease by early detection and treatment) and tertiary prevention (which is to prevent chronic disability by rehabilitation and restoration of normal roles). This classification underlies the organization of the papers and sessions of the conference and it may help to place them in perspective. We have not given equal emphasis to each form of prevention, however, because we believe that there is a growing imbalance between primary and secondary prevention on the one hand and medical care with tertiary prevention on the other.

In individual medical practice the imbalance has always existed and has never been righted. In community, or public health, practice, the imbalance has not always existed, and we might hope that it can be righted if due attention is given. The origins of the 19th century

public health movement were bound up with primary prevention. Chadwick's introduction of closed-circuit water supplies and sewage systems probably improved the health of communities in industrialized countries more than has any other single measure since that time –at any rate up to World War II, when rampant infectious disease was finally brought under control. The community-health needs that then became apparent required a different approach. The population was growing and aging, and we were confronted by an untold mass of chronic disease of uncertain cause. The purposes of the new generation concerned with public health at that time (which was my generation and that of many who will speak at this conference) were two: first, to shift epidemiology from its preoccupation with the search for the specific causes of infectious diseases and their control to the search for the multiple causes of major chronic diseases; second, to shift public health practice from the preoccupation with sanitation, vaccination, and the like–that is, from primary and secondary prevention–toward tertiary prevention.

We aimed to make the care of chronic disease a legitimate and major public health concern. This gave rise to the medical-care movement in public health. However, the reforms of one era often become the abuses of the next, just as the asylums of the 19th century became the snakepits of the mid-20th century. While the analogy is drastic, I fear that the movement we pressed so enthusiastically has begun to justify the fears of our elders, whom we thought stiffnecked and resistant to the needs of the times. The sons of the primal family in Freud's *Totem and Taboo* banded together to murder the father. Perhaps we too have come close to destroying the motivating spirit of prevention in the community-health movement.

Across the country, I believe, the dominant interest of schools of public health and of medicine in their relations with society are those of medical care or health care, in either case meaning the bringing of services to the sick. This is an important function, but few now pursue the goal of prevention with either serious intent or much hope. It is time to begin to redress the balance. We need to find the causes of disease when we do not know them. Where we do know causes, we need to develop appropriate techniques of prevention; where we know the causes and have the techniques, we need to have them applied to the appropriate populations.

At this conference we shall examine the technology and the implementation of prevention. The first panel will consider the overview. The second and third will illustrate the general problems and principles in one session with specific examples from cancer and heart disease, and in another with examples from mental illness and mental retardation. The fourth panel will consider the important problem of implementation.

Let us now turn to the first of our distinguished speakers.